WISCONSIN MEDICAID

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs Completion Instructions, HCF 11094A.

Pharmacy providers are required to have a completed PA/PDL for Cytokine and CAM Antagonist Drugs form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a paper PA request.

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)
2. Date of Birth — Recipient
3. Recipient Medicaid Identification Number

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name
5. Strength
6. Date Prescription Written
7. Directions for Use
8. Diagnosis — Primary Code and / or Description
9. Name — Prescriber
10. Drug Enforcement Agency Number
11. Address — Prescriber (Street, City, State, Zip Code)
12. Telephone Number — Prescriber
13. **SIGNATURE** — Prescriber
14. Date Signed

SECTION III — CLINICAL INFORMATION FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS

15. Prescribers are required to complete this element **only** if PA for a non-preferred drug is being requested. Currently, Amevive is the only non-preferred drug in this class.

    Has the recipient tried and failed a preferred cytokine or CAM antagonist drug or had an adverse drug reaction to a cytokine or CAM antagonist drug? ☐ Yes ☐ No

    If yes, indicate the failed preferred cytokine or CAM antagonist drug or the adverse drug reaction experienced by the recipient.

16. **Psoriasis**
    - A. Does the recipient have a diagnosis of moderate to severe plaque psoriasis (greater than or equal to 10 percent of body surface area) **and** significant functional disability? ☐ Yes ☐ No
    - B. Does the recipient have a diagnosis of debilitating palmar/plantar psoriasis? ☐ Yes ☐ No
    - C. Did a dermatologist write the prescription? ☐ Yes ☐ No
    - D. Has the recipient tried and failed or had an adverse reaction to a methotrexate dose greater than or equal to 15 mg per week, or has the recipient tried and failed or had an adverse reaction to Soriatane? ☐ Yes ☐ No

Continued

SECTION III — CLINICAL INFORMATION FOR CYTOKINE AND CELL ADHESION MOLECULE (CAM) ANTAGONIST DRUGS (Continued)

For PA approval, providers must check "yes" for A or B and "yes" for C or D.

17. **Rheumatoid Arthritis**

A. Does the recipient have a diagnosis of moderate to severe rheumatoid arthritis? ☐ Yes ☐ No

B. Does the recipient have a diagnosis of polyarticular juvenile rheumatoid arthritis, ankylosing spondylitis, or psoriatic arthritis? If yes, indicate the diagnosis in the space provided. ☐ Yes ☐ No

C. Has the recipient tried and failed or had an adverse reaction to one of the drugs listed below? Check the appropriate box to indicate which drug(s) the recipient tried and failed or had an adverse reaction to: ☐ Yes ☐ No

☐ Arava ☐ Cuprimine ☐ hydroxychloroquine ☐ cyclosporine
☐ gold ☐ azathioprine ☐ sulfasalazine

D. Has the recipient tried and failed or had an adverse reaction to a methotrexate dose greater than or equal to 20 mg per week as a single agent or in combination with an agent listed in Element 17C? ☐ Yes ☐ No

SECTION IV — PHARMACY PROVIDERS USING STAT-PA

18. National Drug Code (11 digits)

19. Days' Supply Requested*

20. Wisconsin Medicaid Provider Number (Eight digits)

21. Date of Service (MM/DD/YYYY) (For STAT-PA requests, the date of service may be up to 31 days in the future or up to 14 days in the past.)

22. Place of Service (Patient Location) (Use patient location code "00" [Not specified], "01" [Home], "04" [Long Term / Extended Care], "07" [Skilled Care Facility], or "10" [Outpatient].)

23. Assigned Prior Authorization Number (Seven digits)

24. Grant Date

25. Expiration Date

26. Number of Days Approved

SECTION V — ADDITIONAL INFORMATION

27. Include any additional information in the following space.

*Days' supply requested equals the total number of days requested on the PA. For example, for a one-year PA, providers should enter "365."

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